

STATE OF MICHIGAN

Department of State—Division of Vital Statistics

TRANSCRIPT OF CERTIFICATE OF DEATH

Registered No. *3*

County *Eaton*

Township *Vermontville*

Village *Vermontville*

City *(No. If death occurred in a hospital or institution, give its NAME instead of street and number.)*

2 FULL NAME *Cinderella Mosier*

(a) Residence. No. *(Usual place of abode.)* St., Ward. *(If non-resident give city or town and State.)*
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 Color or Race <i>White</i>	5 Single, Married, Widowed or Divorced (write the word.) <i>Widow</i>
5a If married, widowed, or divorced HUSBAND or WIFE of <i>Lyman Mosier</i>		
6 DATE OF BIRTH (Month, day and year.) <i>Dec 15 1844</i>		
7 AGE Years <i>90</i>	Months <i>3</i>	Days <i>14</i>
If LESS than 1 day, hrs. OR min.		

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Retired*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Syracuse, N.Y.*

PARENTS

10 NAME OF FATHER <i>Samuel Hollister</i>
11 BIRTHPLACE OF FATHER (city or town) (State or country) <i>New York</i>
12 MAIDEN NAME OF MOTHER <i>Liana Miller</i>
13 BIRTHPLACE OF MOTHER (city or town) (state or country) <i>Perm</i>

14 Informant *Lyman Mosier*
(Address) *Vermontville Mich*

15 Filed *4/2, 1935*
L.H. Hobbs
Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day and year) *3/29 1935*

17 I HEREBY CERTIFY, That I attended deceased from *June 29, 1933*, to *Mar 29, 1935*, that I last saw her alive on *Mar 29, 1935* and that death occurred on the date stated above at *7 P.* m.

The CAUSE OF DEATH* was as follows:
Streptococcus Infection of Throat

(duration) yrs. mos. ds. *4*

CONTRIBUTORY (Secondary) *Seriously*

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *L. Donald Kelly M.D.*
19 Address *Vermontville*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for further instructions.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Date of Burial

Shesham *3/31 1935*

2 UNDERTAKER Address

R.R. Ward *Vermontville*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING